RESET FORM

WAIVER OF PREMIUM DISABILITY CLAIM

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)
Members of the Voya family of companies
(the "Company")
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440, Toll-Free: 888-238-4840
Voya Life Claims Overnight Address: 20 Washington Avenue So, Minneapolis, MN 55401

VOYA FINANCIAL™

The Group, Employee, Claim Information and Certification sections must be completed by the employer. The Insured is responsible for completion of the remainder of the form. The separate Attending Physician's Statement must be completed by the Insured's attending physician. The completed forms must be sent to the above address along with copies of the Insured's enrollment forms, change forms, absolute assignments, and beneficiary changes.

CLAIM CHECKLIST

☐ Is the Employer Certification complete and signed?
☐ Has the employee completed the Insured Statement and signed the Authorization and Acknowledgment section?
☐ Has the Attending Physician's Statement been given to the employee for completion?
☐ Has the employee signed the Authorization for Release of Health Related Information?
☐ Has the Consumer Privacy Notice been given to the employee?
☐ Is the enrollment documentation and beneficiary information attached?

GROUP INFORMATION

Group Name _____

Group Number _____ Account Number _____

EMPLOYEE INFORMATION

Insured Name _____

Birth Date _____ SSN _____

Address _____ City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widow(er) Gender: ☐ Male ☐ Female

Job Title _____ Employment Start Date _____ Date Last Worked _____

Salary $ _____ per: ☐ hour ☐ week ☐ month ☐ year Last Salary Change Date _____

Employment Status: ☐ Full Time ☐ Part Time Average hours per week _____ ☐ Union ☐ Non Union

COVERAGE INFORMATION

Basic Life $ _____ Effective Date _____ Supplemental Life $ _____ Effective Date _____

Optional Life $ _____ Effective Date _____ Other $ _____ Effective Date _____

EMPLOYER CERTIFICATION

The undersigned certifies that the above statements as to the insured are correct as reported on its records.

Employer Name _____

Employer Address _____ City _____ State _____ ZIP _____

Authorized Signature _____ Date _____

Title _____ Phone (_____)_____ E-mail _____

INSURED STATEMENT *(Use separate sheet to provide additional information if needed.)*

Describe condition or illness _____

Attending Physician Name *(please print)* _____ Date _____

Address _____ City _____ State _____ ZIP _____

Cause _____

Insured Name _____ SSN _____ Group Number _____

INSURED STATEMENT *(Continued)*

Other Attending Physician Name *(please print)* _____ Date _____

Address _____ City _____ State _____ ZIP _____

Cause _____

Date You Last Worked _____ Date You Became Totally Disabled _____

Are you receiving any other disability benefits? . . . . . ☐ Yes ☐ No

If "Yes," what type? _____

Are you house confined? . . . . . ☐ Yes ☐ No

Are you bed confined? . . . . . ☐ Yes ☐ No

Are you receiving any wages or salary? . . . . . ☐ Yes ☐ No

If "Yes," what type? _____

Have you returned to work? . . . . . ☐ Yes ☐ No

If "Yes," what date? _____

Do you expect to return to work? . . . . . ☐ Yes ☐ No

If "Yes," what date? _____

EDUCATIONAL BACKGROUND *(Please check the highest grade completed.)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ AA ☐ AS ☐ BA ☐ BS ☐ MA ☐ Ph.D ☐ Other _____

AUTHORIZATION AND ACKNOWLEDGMENT

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., Social Security Administration or employer to give the Company or its agents, employees and authorized representatives acting on its behalf (including ChoicePoint or any consumer reporting agency), ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information, as they apply to me. I give my permission to the Company to get consumer or investigative consumer reports about me.

I give my permission to the Company to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations -- 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between the Company and its affiliates and may be sent to MIB. This information may be made available to any Company affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with the Company or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given the Company's Consumer Privacy Notice and Insurance Information Practices Notice.

I hereby certify that the statements on this form are complete and accurate to the best of my knowledge.

Insured Signature _____ Date _____

Home Phone (_____)_____ Home E-mail _____

Insured Name _____ SSN _____ Group Number _____

FRAUD WARNINGS

Alaska, Alabama, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.